LETTERS TO THE EDITOR

Chlamydial infections in children

EDITOR,—We know that *Chlamydia trachomatis* infections (serovars D-K) are a significant cause of morbidity in the adult population, particularly young women. This justifies the considerable efforts and costs of preventing, diagnosing, and treating chlamydial infections. It is also well established that *C trachomatis* can cause conjunctivitis and pneumonitis in neonates and infants as a result of vertical transmission.

There is no doubt that symptomatic children should be treated but should we also treat asymptomatic carriers? What would be the benefit of treating asymptomatic children of mothers who were proved or have a history suggestive of *C trachomatis* infection during their pregnancy? Should we treat these children systematically? Up to what age? These questions have recently arisen in our department after the diagnoses of *C trachomatis* conjunctivitis in several small children.

The American guidelines for the management of sexually transmitted infection[1] do not recommend prophylactic treatment to infants of chlamydia positive mothers but close clinical supervision and treatment if symptoms develop. These guidelines do highlight the importance of antenatal screening as the main preventive measure in the vertical transmission of *C trachomatis*. Routine prophylaxis with silver nitrate or topical antibiotics would not prevent *C trachomatis* transmission. Neither the UK national guidelines nor the SIGN (Scottish Intercollegiate Guidelines Network) guidelines[2 3] address the issue.

In preadolescent children sexual abuse should always be considered when a diagnosis of *C trachomatis* has been made, although there are reports of perinatally transmitted infections up to the age of 3[4] and in our department a family cluster of *C trachomatis* infection has recently been reported, including a 6 year old girl in whom there was no evidence of sexual abuse.[5]

We await with interest the results of the pilot chlamydial screening projects in Portsmouth and the Wirral but suggest that routine antenatal screening for *C trachomatis* infections with a nuclear amplification test (NAT) would reduce perinatal and infant morbidity and possible infection in children, whether symptomatic or not. At the very least, targeted antenatal screening of higher risk groups (young pregnant women up to 25, or those with new or multiple partners, as recommended by the American guidelines) should be clearly specified in the current UK guidelines.

A negative reliable chlamydial test documented during a pregnancy would make a diagnosis of *C trachomatis* infection in a child less likely to be of vertical perinatal transmission.

In the meantime, what should we do? Investigating and treating asymptomatic children as "contacts" may cause unnecessary anxiety and unpleasantness to both child and parents. Epidemiological antibiotic treatment is not exempt of risks to the individual patient and is likely to increase resistance in the general population.

We would welcome the view of clinicians and thus perhaps open a debate in an area of sexually transmitted infections in which not much is known.

C OROZ
K A M PORTER-BOVERI
C THOMPSON
Department of Genito-Urinary Medicine, Victoria Hospital, Hayfield Road, Kirkcaldy, Fife KY2 5AH, UK

Correspondence to: Dr Oroz

1 Centres for Disease Control and Prevention. *Guidelines for treatment of sexually transmitted diseases.* Atlanta, GA: US Department of Health and Human Resources (CDC), 1998.
2 UK national guidelines on sexually transmitted infections and closely related conditions, sexually transmitted infections. *J Sex Health HIV* 1999;**75**(Suppl 1).
3 Scottish Intercollegiate Guidelines Network. *Management of genital chlamydia trachomatis infection. National Clinical Guideline*. March 2000, Pub No 42.
4 Schachter J, Grossman M, Sweet RL, *et al.* Prospective study of perinatal transmission of Chlamydia trachomatis. *JAMA* 1986;**255**: 3374–7.
5 Thompson C, Macdonald M, Sutherland A. A family cluster of Chlamydia trachomatis infection. *BMJ* 2001;**322**:1473–4.

Accepted for publication 30 August 2001

Self treatment among a sample of first time attenders at a genitourinary medicine clinic

EDITOR,—Many people self medicate or seek advice from others before attending a medical consultation and while this has been documented for a number of conditions, there is little reason to suppose the behaviour will be different for a sexually transmitted infection (STI). There may be specific problems with self medication for STIs since they may mask signs and symptoms and unprescribed use of antibiotics may select for resistance among strains of *Neisseria gonorrhoeae* and other bacteria residing within and outside the genital tract.[1] We examined all aspects of self care in a sample of first time attenders at a GUM clinic in the United Kingdom. There were 492 consecutive first time attenders in a 3 month period, of which we achieved the participation of 188 clients (128 females, 60 males).

Information was collected via structured interview carried out by a health adviser. We asked about a range of issues concerning treatment seeking and symptoms experienced by clients. We specifically asked clients what measures they had taken between suspecting an STI and attending the clinic. Forty four respondents (23%) reported using a medication or remedy before attending the clinic. A total of 80 remedies were mentioned. The most commonly reported treatment was the use of Canesten (n=15), followed by paracetamol (n=5), antibiotics (n=5), Diflucan (n=3), and unspecified pessaries (n=3). Sixteen other medications were reported, of which 12 were identified by brand name. Two respondents (one on the recommendation of her mother) reported drinking lemon barley water and one drank cranberry juice. One person drank more water than usual, another drank less. Avoiding milk and bread, eating live yoghurt, and taking bicarbonate of soda were all mentioned by at least one respondent. Most medications were acquired either from the chemist or from trusted others; these latter included a wife, a sister, two friends, and two mothers.

These findings fit well with data from other countries and support a large US study.[2] The wide range of self treatments attests to the lack of knowledge about what might or might not "work" as a treatment for the symptoms of a sexually transmitted infection. The very large number of named "products" is striking. Remedies involving changing eating and drinking patterns are fairly common and are usually the consequence of advice from others. Given the stigma associated with having a suspected STI it is not surprising that only a few respondents discussed their treatment strategy with others.

It is important that genitourinary clinic staff recognise that a significant proportion of people attending will have tried some form of self medication. It would be desirable to establish which products have been tried and how recently. There is also an opportunity here for offering advice and education for the future and ensuring that there is good understanding of the role of antibiotics.

M K PITTS
S CANNON
G SINGH
Australian Research Centre, sex, Health & Society, La Trobe University, 215 Franklin Street, Melbourne, Victoria 3000, Australia

Correspondence to: Professor Pitts
m.pitts@latrobe.edu.au

1 Gordon SM, Mosure DJ, Lewis J, *et al.* Prevalence of self-medication with antibiotics among patients attending a clinic for treatment of sexually transmitted diseases. *Clin Infect Dis* 1993;**17**:462–5.
2 Irwin D, Thomas JC, Spitters CE, *et al.* Self-treatment patterns among clients attending sexually transmitted disease clinics and the effect of self treatment on STD symptom duration. *Sex Transm Dis* 1997;**24**:6:372–7.

Accepted for publication 30 August 2001

Circumcision and STD in the United States

EDITOR,—The study by Diseker *et al*,[1] though examining too small a study population to obtain statistically meaningful results in some aspects, is commendably objective. Their study tends to confirm previous research findings relative to circumcision versus syphilis and gonorrhoea, the majority of which indicate a strong (protective) relation between the non-circumcised state and syphilis and a weaker relation with gonorrhoea.

A brief examination of this and several previous studies going back 150 years on circumcision versus syphilis and gonorrhoea reveals an intriguing relation: syphilis is proportionally lower in circumcised men than it is in uncircumcised men.

In 1855, Hutchinson,[2] in England, reported a syphilis:gonorrhoea ratio of 0.23:1 for Jews and 1.54:1 for non-Jews (all ratios in this letter are my re-expressions of the original data). In 1934 Wolbarst,[3] a NY urologist examining 1500 cases, reported a ratio of syphilis and chancroid to gonorrhoea of 0.36:1 for circumcised men and 0.78:1 for uncircumcised men (only 5–25% of American men were routinely circumcised in the late 19th century/early 20th century).[4] I note from Diseker *et al*'s table 2 (Cross section analysis at baseline) that the ratio of syphilis to gonorrhoea is 0.06:1 in circumcised men